Exhibit 13

MINISTRY HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Thomas A Smith
Name of Patient/Previous Names

1-31-52
Birth Date/Medical Record Number

10 Sanns Street
Street Address

Rhinelander WI (715)362-9673
City, State, Zip, Phone Number

AUTHORIZES DISCLOSURE BY:

ST. Mary's
Name of Health Care Provider/Plan/Other

Street Address

Rhinelander WI 54501
City, State, Zip Code

DISCLOSURE OF HEALTH INFORMATION TO:

Alan J. Smith
Name of Health Care Provider/Plan/Other

2452 County C
Street Address

Rhinelander, WI 54501
City, State, Zip Code

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*

- ☒ Discharge Summary
- ☒ History & Physical
- ☒ Consultation
- ☒ Operative Report
- ☒ Pathology Report
- ☒ Radiology Report-Films
- ☒ Laboratory Report
- ☒ Rehab Notes
- ☐ ED Report
- ☒ Other: Hosaic notes

DISCLOSURES REQUIRING SPECIAL CONSENT: In compliance with Wisconsin Statutes which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed. Check all that apply.

- ☐ HIV/AIDS*
- ☐ Mental/Behavioral Health Conditions
- ☐ Drug/Alcohol Abuse/Treatment

FOR THE FOLLOWING DATES: From: 04-7-17 To 04-18-017

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

- ☐ Continuing Care
- ☐ Transfer to New Provider
- ☐ Insurance/Claim Purposes
- ☒ Legal Investigation
- ☐ Disability Determination
- ☐ Personal Use
- ☐ Workers Compensation
- ☐ Vocational Rehab Eval
- ☐ Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Receive a Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I must be provided with a copy. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that Ministry Health Care may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.** **Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the organization's Medical Record/Health Information Management Department. I am aware that my withdrawal will not be effective until received by the organization and will not be effective regarding the uses and/or disclosures of my health information that the organization has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by Federal privacy standards. ***HIV Test Results:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. ****WI Statutes 51.30 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy or Facsimile (FAX) Valid as an Original.**

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP.: Alan J. Smith **DATE:** 9-7-17
(If signed by other than patient, state relationship and authority to do so.)

FOR ORGANIZATIONAL USE					
Dt Received:	Dt Disclosed:	Processed By:	☐ Mailed	☐ Faxed	☐ Picked Up By:

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate [redacted]1952
Hosp History and Physical
Service: 04/07/2017
Trung Tran DO

Printed: 09/07/17
At: 08:35

*** COPY ***

Document Dates
4/7/17

Chief Complaint
Hyperglycemia.

History of Present Illness
This 65-year-old, nonverbal, Caucasian male with a history of diabetes mellitus type 2, CKD stage 3, bulbar weakness secondary to CVA, Parkinsons, and diabetes mellitus type 2 is brought in to the emergency room after sustaining a closed-head injury. Apparently this patient is unable to speak and had some issues where he believed he was in distress. He does not have a TTY machine at home, attempted to call 9-1-1 and through a lot of miscommunication 9-1-1 dispatcher concluded there was some sort of shooting versus a bomb threat resulting in police cordoning off downtown Rhinelander.

According to patient's son, when patient emerged from his home, police thought he was the bomber/shooter suspect and proceeded to tackle and restrain this elderly man. He is unable to communicate verbally and was brought into the emergency room where it was discovered patient has hyperglycemia. Most of the history is obtained from his son since the patient is nonverbal and only able to communicate via written form. History is limited because of communication difficulties.

According to the son, primary care provider lowered the evening NPH to 18 units because of morning hypoglycemia. The patient has difficulty drawing up his own insulin and son questions if patient is able to administering insulin correctly. Patient's son says they are working to get Medicaid/Medicare coverage and additional assistance.

Patient has been seeing a speech therapist due to dysphagia issues. There is suspicion patient is silently aspirating per speech therapist's note. The patient has been losing approximately 7-8 pounds per week due to poor appetite. Patient denies any fevers, chills or body aches by shaking his head. No other active issues are obtainable at this time.

Past Medical History
1. Recent CVA.
2. Parkinson's disease.
3. Diabetes mellitus type 2 on insulin, diagnosed 1980s.
4. Essential hypertension.
5. Bulbar weakness with severe dysarthria and upper extremity weakness, 2006.
6. Degenerative joint disease.
7. GERD.
8. History of asthma.
9. Nonverbal secondary to recent CVA with Parkinson's.

*** COPY ***

Past Surgical History

1. Appendectomy.
2. Trigger finger release.
3. Bilateral carpal tunnel release.
4. Sinus surgery, 1990s.

Medications

VERIFIED AS ACTIVE IN MEDICATIONS MANAGER:

Acetaminophen (Tylenol®), by mouth as needed 2am 3 hs
AmLODIPine 10 mg Tablet, 1 Tablet(s) by mouth once daily
Aspirin, by mouth 81 mg 1 daily
Beclomethasone Dipropionate (Qvar®) Inhalation 80 mcg/Actuation Aerosol, 2 Puff(s) twice daily
Chlorhexidine Gluconate Mucous Membrane 0.12 % Mouthwash, 15 Milliliter(s) by mouth up to twice daily
Finasteride 5 mg Tablet, 1 Tablet(s) by mouth once daily
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100 unit/mL Insulin Pen, subcutaneously 4units breakfast, 0-2 units lunch, 11 units dinner, +SS max daily dose = 30units
Insulin NPH Human Recombinant (Humulin N KwikPen®) Subcutaneous 100 unit/mL (3 mL) Insulin Pen, subcutaneously 18 units am,18 units pm
Irbesartan 150 mg Tablet, 1 Tablet(s) by mouth once daily
Omega-3 Fatty Acids (OTC) (Natural Fish Oil®), by mouth 1000 mcg daily
Omeprazole 20 mg Capsule, Delayed Release(E.C.), 1 Capsule(s) by mouth once daily
Simvastatin 20 mg Tablet, 1/2 Tablet(s) by mouth once daily
Spironolactone 25 mg Tablet, 1 Tablet(s) by mouth once daily
Tamsulosin 0.4 mg Capsule, Sust. Release 24HR, 1 Capsule(s) by mouth once daily

Allergies

Hydrochlorothiazide: possible pancreatitis
Liraglutide Subcutaneous (Victoza 2-Pak®): Nausea

Family History

Pertinent for unknown cancer in his father who passed away from his disease. His mother had diabetes mellitus type 2, arthritis and hypertension. She is also deceased.

Social History

The patient lives at home with his son. The patient is retired from Smith and Foster. No history of tobacco, alcohol or illicit drug use or abuse.

CODE STATUS:
DNR.

Review of Systems

Review of systems could not be obtained due to patient condition.

Examination

VITAL SIGNS: Temperature 97.6, blood pressure 159/105, pulse 118, respirations 22, O2 saturation 93% on 2 liters.
GENERAL: Cachectic Caucasian male, nonverbal, disheveled appearance.
SKIN: The patient has abrasions on the right periorbital temporal region. Discoloration around the perioral region as well from emesis in the past. Multiple nevi in posterior back.
HEENT: Head: The patient appears to have a suffered a closed-head injury with bleeding on the right temporal region. Normocephalic. Ears: No tenderness or discharge. Auditory acuity cannot be assessed due to patient condition. Nose/sinuses: No inflammation of the nasal mucosa/septum/turbinates. Maxillary and frontal sinuses are mildly tender. Posterior pharynx and oral mucosa are dry.
BACK: Limited examination due to decreased range of motion.
HEART: Barely audible S1, S2. Mild systolic murmur appreciated left sternal border.
LUNGS: Diminished lung sounds diffusely. Mild expiratory wheezes on the right base.
ABDOMEN: Bowel sounds in all 4 quadrants. No rebound, guarding or hepatosplenomegaly appreciated.
MUSCULOSKELETAL: Decreased range of motion and physical deconditioning. Atrophy in muscles diffusely.
NEUROLOGICAL: Limited examination due to patient condition. The patient is nonverbal. Reflexes in the triceps, biceps, brachial radialis are 2/4 bilaterally. Negative Babinski. Cerebellar and finger-to-nose test grossly intact.
PSYCHOLOGICAL: Limited examination due to patient condition. The patient appears to have mild dementia.

Laboratory/X-Ray

WBC 20.3, hemoglobin 17.6, hematocrit 48.4, platelet 204, MCV 92.9, RDW 12.3. INR 1.2. Troponin I less than 15. ABG 7.36/46/74/26. Sodium 135, potassium 4.1, chloride 197, bicarb 26, BUN 45, creatinine 1.27, calcium 9.5. Blood glucose 559. Alk phos 117, ALT 55, AST 32. Magnesium 1.5. TSH is 0.98, free T4 1.5. Urine drug screening negative. Blood alcohol less than 20.

Radiology:

Portable chest, 1 view, image reviewed by myself reveals possible right lower lobe infiltrate. Poor inspiratory effort. Loops of bowel noted in thoracic cavity, possibly due to angle.

CT head without contrast obtained on 4/7/17:
IMPRESSION:
No intracranial hemorrhage or other acute abnormality by CT.

Cervical spine with an without contrast obtained on 4/7/17:
IMPRESSION:
No acute findings on cervical spine.

CT maxillofacial with and without contrast obtained on 4/7/17:
IMPRESSION:
No facial fracture identified. Superficial metallic debris along the right cheek and adjacent to the right

anterior globe. Extensive periodontal disease with absent right-sided maxillary and mandibular teeth.

Impression

1. Hyperglycemic hyperosmolar syndrome.
2. Suspect sepsis secondary to aspiration pneumonia.
3. Closed-head injury.
4. Leukocytosis secondary to #2.
5. Uncontrolled hypertension.
6. Acute hypomagnesemia.

Plan

The patient is admitted to the acute care unit, DNR code status, guarded condition as inpatient.

1. Hyperglycemic hyperosmolar syndrome. The patient is started on insulin per HHS protocol. We will readjust his insulin pending clinical course. He will receive normal saline IV fluids running at 100 mL per hour. Cautious use of IV fluids due to concern for volume overload.
2. Suspect sepsis secondary to aspiration pneumonia. The patient meets sepsis criteria with leukocytosis, tachypnea and tachycardia. Chest x-ray demonstrates possibility of pneumonia. The patient silently aspirates due to dysphagia. He is started on IV Vancomycin and Zosyn. No fevers are appreciated at this time. IV fluids are being provided as mentioned above. Will deescalate antibiotics pending cultures.
3. Closed-head injury. The patient sustained a laceration/abrasion on the right periorbital temporal region after being tackled by police. Extensive imaging of the head did not demonstrate any significant findings but we will monitor at this time. Wound care nurse has been consulted for dressing changes.
4. Leukocytosis secondary to #2. WBC is elevated at 20.3. He is provided IV fluids and IV antibiotics as mentioned above.
5. Uncontrolled hypertension. Blood pressure is elevated at 159/105. This might be due to the acuity of his presenting symptom. We have restarted his home medications and will readjust if it remains elevated.
6. Acute hypomagnesemia. The magnesium is 1.5. The patient will be given 2 grams of magnesium sulfate via IV 1 time. Repeat magnesium level in a.m.

DVT prophylaxis with Lovenox 40 mg subcu daily.
GI prophylaxis with home medication Omeprazole 20 mg p.o. daily.

Dr. Steven Brooks will assume care in a.m.

Justification for inpatient admission. This patient presents with hyperglycemia hyperosmolar syndrome with blood glucose of greater than 500 requiring insulin. There is also suspicion of sepsis from aspiration pneumonia. He is on IV Vancomycin and Zosyn. Will likely require at least a 2 midnight stay.

Patient care time 120 minutes reviewing patient chart, labs, examining patient, discussing with patient and hospital staff medical care plan.

*** COPY ***

Trung Tran DO/se/lja
Hospitalist

Dictated: 04/07/2017 at 23:41
Transcribed: 04/08/2017 at 01:22

EC:
Steven R Brooks MD

Electronically signed by Tran, Trung DO on 04/13/2017 22:24.

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate [redacted]/1952
Emergency Department Note Hosp
Service: 04/07/2017
Richard F Mickevicius MD

Printed: 09/07/17
At: 08:35

*** COPY ***

Patient seen 4/7/17.

FINAL IMPRESSION:
1. Hyperosmolarity.
2. Hyperglycemia.
3. Dehydration.
4. Leukocytosis.
5. Altered mental status.
6. Closed-head injury.
7. Contusions.
8. Abrasions.

Chief Complaint
Altered mental status.

History of Present Illness
The patient is a 65-year-old man who apparently called in through a TTY phone about shots being fired and bombs being rigged. A SWAT team was involved. Eventually the patient was placed in custody. In the process of doing so he was tackled to the ground. He sustained some abrasions. He was brought in to be evaluated. He himself does not communicate well. He communicates through writing. He apparently has not had any fevers, vomiting, diarrhea, chest pain, shortness of breath currently. Complained of some pain where he was struck. He had some chest pain previously. No urinary complaints. We do not know about medical compliance.

Past Medical History
1. Hypertension.
2. Asthma.
3. Gastroesophageal reflux disease.
4. Degenerative joint disease.
5. Diabetes type 2.
6. Microalbuminuria.
7. Allergic rhinitis.
8. Appendectomy.
9. Trigger finger release.
10. Bilateral carpal tunnel release.
11. Sinus surgery.
12. BPH.
13. Elevated PSA.
14. Bulbar weakness.
15. Severe dysarthria.

*** COPY ***

Medications
Please see his reconciled list, but they include:
1. Acetaminophen.
2. Amlodipine.
3. Aspirin.
4. QVAR.
5. AccuCheks.
6. Chlorhexidine.
7. Finasteride.
8. NovoLog.
9. Irbesartan.
10. Omega-3 fatty acids.
11. Omeprazole.
12. Simvastatin.
13. Spironolactone.
14. Flomax.

Allergies
1. HYDROCHLOROTHIAZIDE.
2. VICTOZA.

Family History
Noncontributory.

Social History
No tobacco, alcohol or drug use. He is retired from Foster & Smith.

Review of Systems
Please see HPI for pertinent positives and negatives, otherwise unknown as patient did not respond to all our questions, only some of them.

Examination
VITAL SIGNS: Per nursing notes.
CONSTITUTIONAL/PSYCHIATRIC: Well-nourished, well-developed, elderly man, awake, alert, follows commands, but has difficulty speaking.
HEENT: Head is normocephalic. He sustained abrasions to the forehead on the right side of his face. Eyes, sclerae anicteric. Conjunctivae not injected. Pupils 2-3 mm, round, reactive to light. Extraocular movements are intact. Ears, nose, mouth and throat: External inspection of ears and nose shows no acute abnormality. Oropharyngeal examination, patient had some bleeding from his gums. He had what looked like was probably an avulsion to his right central maxillary incisor. He has severe dental caries. He had good jaw occlusion.
NECK: The patient was in a cervical collar. No bony crepitus, stepoffs or apparent tenderness.
BACK: No bony crepitus, stepoffs of apparent tenderness.
RESPIRATORY: Normal respiratory effort. Auscultation of the lungs revealed no wheezes, crackles,

gurgles or stridor.
CARDIOVASCULAR: Auscultation reveals regular rate and rhythm. No murmurs, gallops or rubs. Peripheral pulses were 2+ and symmetrical.
EXTREMITIES: No nontraumatic edema. He had abrasions to his arms and knees but was moving his extremities once he was uncuffed with 5/5 strength.
NEUROLOGIC: Facial movement intact and symmetrical. Tongue protrusion midline. Palate is upgoing. Sensation is intact to light touch in extremities times 4.

MEDICAL DECISION MAKING:
The patient presents with above complaint. His tetanus is technically up to date. He last received one in October of 2007. He was sent for scanning of his head, face and neck. He had no facial fractures. No fractures of the cervical spine. No intracranial hemorrhage or other acute abnormality by CT. Labs returned. White count was 20.3 thousand. Hemoglobin 17.6, platelets 204. Beta hydroxybutyrate was 0.7. AccuChek done at bedside was 563. Serum glucose was 559 with a BUN of 45, creatinine 1.27. Magnesium 1.5, total bili 1.3. Alk phos, ALT, AST were all normal. Troponin is less than 15. Acetaminophen is less than 2. Salicylate less than 1.7. Ethanol less than 20. TSH, free T4 were 0.9 and 1.5 respectively. Serum osmolality was 329 which is elevated, normal range being 282 to 305. INR is 1.2. PTT is 27. Chest x-ray was portable technique but it looks like he could have an infiltrate right lower lobe. Blood cultures, lactate, procalcitonin were ordered. The patient's EKG today showed sinus tachycardia, rate of 103, an occasional PAC. He has a lot of baseline artifact. I see no definite ST segment elevation or depression. No T-wave changes to suggest ischemia or injury. The computer called T-wave abnormality considering inferior ischemia but he has a lot of artifact. When we looked back to his previous EKGs, all the most recent ones have the same type of artifact and changes.

At this point I think the patient requires admission. He was started on a non-DKA insulin drip protocol. After cultures are obtained we will discuss with Dr. Tran administration of antibiotic.

Impression
Final impressions remain as dictated. In addition, will add: Rule out sepsis.

Richard Mickevicius, MD/rs
Emergency Medicine

Dictated: 04/07/2017 at 21:56
Transcribed: 04/07/2017 at 23:46

Electronically signed by Mickevicius, Richard F MD on 04/07/2017 23:54.

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]/1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ICU 2252-A
Patient Status: ADM IN
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

RAD CHEST 1 VIEW PORT
04/07/2017 259923

CLINICAL HISTORY: Altered mental status.

COMPARISON: 3/20/2015.

FINDINGS: Heart size is normal. Lungs appear hypoinflated. Mild interstitial opacities present in both lungs could be related to a component of interstitial pulmonary edema. Airspace opacities noted in both lung bases could be related to atelectasis, aspiration or developing pneumonia. No definite pleural effusion or pneumothorax is evident. Air-filled bowel loops present in the upper abdomen.

IMPRESSION:
1. Hypoinflated lungs with increased interstitial opacities may be related to a component of interstitial pulmonary edema versus atelectasis from hypoinflation.
2. Airspace opacities in both lung bases could be related to atelectasis, aspiration or developing pneumonia.
Internal Use: Taken: 4/7/2017 9:30 PM

Electronically Signed By: Anthony Rutkowski M.D.
Signed Date/Time: 4/8/2017 7:24 AM
Dictated from workstation: NRIMRADID19
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/08/2017 **

Reported By: A. RUTKOWSKI M.D.
CC: R. MICKEVICIUS

Technologist: GRANT,KATHLEEN
Transcribed Date/Time: 04/08/2017 (0725)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/08/2017 (0726)

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT HEAD WO/C
04/07/2017 259923

HEAD WO/C, 4/7/2017 9:25 PM, SHSM

INDICATION:
TACKLED TO GROUND/HIT HEAD RM 1

ADDITIONAL CLINICAL INFORMATION:
Ordering Provider Reason for Exam:
Technologist Note:
Additional: None

COMPARISON:
1/16/2017

TECHNIQUE:
Noncontrast CT brain was performed utilizing standard protocol. Images are reviewed in bone and soft tissue windows

FINDINGS:
The ventricles and sulci are normal in size and configuration for the patient's age. There is no intracranial hemorrhage, mass effect or midline shift. Brain parenchyma is normal in attenuation.

Visualized portions of paranasal sinuses and mastoid air cells appear clear.
IMPRESSION:
No intracranial hemorrhage or other acute abnormality by CT.
Electronically Signed By: Emily Norman, MD

Signed Date/Time: 4/7/2017 9:32 PM
Dictated from workstation: NCGSPACSD03
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/07/2017 **
Reported By: E. NORMAN M.D.
CC: R. MICKEVICIUS

Technologist: LARSON,KARI
Transcribed Date/Time: 04/07/2017 (2133)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/07/2017 (2133)

PLA 059

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT HEAD WO/C
04/07/2017 259923

PLA 060

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT MAX FACIAL WO/C
04/07/2017 259923

MAX FACIAL WO/C, 4/7/2017 9:25 PM, SHSM

INDICATION:
TACKLED BY POLICE/HIT FACE RM 2

ADDITIONAL CLINICAL INFORMATION:
Ordering Provider Reason for Exam:
Technologist Note:
Additional: None

COMPARISON:
None available at the time of dictation.

TECHNIQUE:
Maxillofacial CT performed with coronal and sagittal reformatted images.

IV CONTRAST:
FINDINGS:
No facial fracture is identified. There is superficial punctate metallic debris at the right orbit and along the right zygomatic arch soft tissues. Punctate metallic foreign bodies are also present adjacent to the anterior right globe. No post septal abnormality or post-septal foreign body is seen.

Globes appear intact.

There is evidence of previous right sinus surgery. Paranasal sinuses are clear.

Multiple dental caries are present. There is some erosive change of the right anterior maxilla with absence of maxillary teeth at this location. There are also absent mandibular teeth on the right.

IMPRESSION:

1. No facial fracture is identified

PLA 061

St. Mary's Hospital
Name: SMITH,THOMAS
DOB: [redacted]1952 Age: 65 Sex: M
10 SANNS ST
RHINELANDER WI 54501
715-362-9673

Location: ED -
Patient Status: REG ER
Ord Phys: MICKEVICIUS MD,RICHARD

Acct: M00016934192
Unit No: M267772

CT MAX FACIAL WO/C
04/07/2017 259923

2. Superficial metallic debris along the right cheek and adjacent to the right anterior globe.
3. Extensive periodontal disease with absent right-sided maxillary and mandibular teeth

See the Radiology Information System for this patient for the contrast type and quantity.

Electronically Signed By: Emily Norman, MD
Signed Date/Time: 4/7/2017 9:38 PM
Dictated from workstation: NCGSPACSD03
** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/07/2017 **
Reported By: E. NORMAN M.D.
CC: R. MICKEVICIUS

Technologist: LARSON,KARI
Transcribed Date/Time: 04/07/2017 (2140)
Transcriptionist: PSCRIBE
Printed Date/Time: 04/07/2017 (2140)

PLA 062

SMITH, THOMAS ID:30108417 07-APR-2017 21:08:32 Ministry Health Care-R.ED ROUTINE RECORD

31-JAN-1952 (65 yr)
Male Unknown

Room:2
Loc:812

Vent. rate	103	BPM
PR interval	120	ms
QRS duration	88	ms
QT/QTc	356/466	ms
P-R-T axes	73 -26	-18

Sinus tachycardia with Premature atrial complexes
T wave abnormality, consider inferior ischemia
Abnormal ECG
No previous ECGs available
Initial interpretation done at 21:08
Electronically signed by Mickevicius MD, Richard (10060) on 4/7/2017 10:48:02 PM

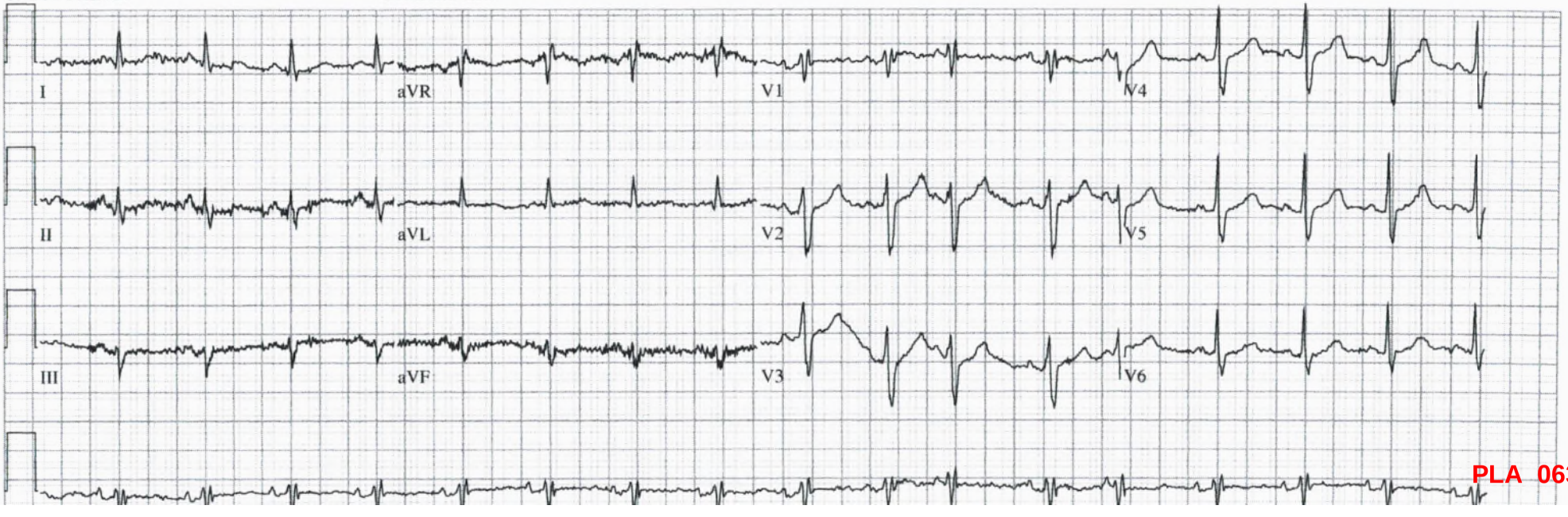
Technician: RLP
Test ind:ALTERED MENTAL STATU

Referred by: MICR

Confirmed By: Richard Mickevicius MD

CHEST PAIN:N

STMARY ER:



PLA 063

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate [redacted]/1952
Admission Medication Intake List
Service: 04/08/2017
Jill M Messenger RN

Printed: 09/07/17
At: 08:36

*** COPY ***

ADMISSION MEDICATION INTAKE LIST
MHC-ST MARY'S-RHINELANDER

Medications

VERIFIED AS ACTIVE IN MEDICATIONS MANAGER:
Acetaminophen (Tylenol®), by mouth as needed 2am 3 hs
AmLODIPine 10 mg Tablet, 1 Tablet(s) by mouth once daily
Aspirin, by mouth 81 mg 1 daily
Beclomethasone Dipropionate (Qvar®) Inhalation 80 mcg/Actuation Aerosol, 2 Puff(s) twice daily
Blood Sugar Diagnostic (Accu-Chek Aviva Plus Test Strip®) Miscell. (Med.Supl.;Non-Drugs) Strip, 1 Strip(s) six times daily
Blood Sugar Diagnostic, Drum (Accu-Chek Compact Plus Test®) Miscell. (Med.Supl.;Non-Drugs) Strip, 1 Strip(s) four to six times daily
Blood-Glucose Meter (Accu-Chek Aviva Plus Meter®) Miscell. (Med.Supl.;Non-Drugs) Misc, As directed SIX TIMES DAILY
Chlorhexidine Gluconate Mucous Membrane 0.12 % Mouthwash, 15 Milliliter(s) by mouth up to twice daily Swish in mouth for 30 seconds and spit out
Finasteride 5 mg Tablet, 1 Tablet(s) by mouth once daily
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100 unit/mL Insulin Pen, subcutaneously 4units breakfast, 0-2 units lunch, 11 units dinner, +SS max daily dose = 30units
Insulin Needles (BD Insulin Pen Needle UF Mini®) Miscell. (Med.Supl.;Non-Drugs) 31 gauge x 3/16" Needle, 1 Needle(s) five times daily
Insulin NPH Human Recombinant (Humulin N KwikPen®) Subcutaneous 100 unit/mL (3 mL) Insulin Pen, subcutaneously 18 units am,18 units pm
Insulin Syringe-Needle U-100 Miscell. (Med.Supl.;Non-Drugs) Syringe, 1 Syringe(s) subcutaneously four to six times daily
Irbesartan 150 mg Tablet, 1 Tablet(s) by mouth once daily
Lancets (Soft Touch Lancets®) Miscell. (Med.Supl.;Non-Drugs) Misc, 1 Lancet(s) six times daily
Omega-3 Fatty Acids (OTC) (Natural Fish Oil®), by mouth 1000 mcg daily
Omeprazole 20 mg Capsule, Delayed Release(E.C.), 1 Capsule(s) by mouth once daily
Simvastatin 20 mg Tablet, 1/2 Tablet(s) by mouth once daily
Spironolactone 25 mg Tablet, 1 Tablet(s) by mouth once daily
Tamsulosin 0.4 mg Capsule, Sust. Release 24HR, 1 Capsule(s) by mouth once daily

Plan

Disposition: NO MEDICATIONS BROUGHT IN WITH PATIENT

Jill M Messenger, RN
Patient Care Services

Created: 04/08/2017

PLA 064

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Admission Medication Intake List, Page 2 *** COPY ***

Electronically signed by Messenger, Jill M RN on 04/08/2017 01:23.

PLA 065

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate: [redacted]/1952
Hosp Consult-Psych
Service: 04/11/2017
Harriet I Walker PhD

Printed: 09/07/17
At: 08:36

*** COPY ***

COMPETENCY EVALUATION

LENGTH OF ASSESSMENT: 30 minutes 1:1 with patient in interview and testing; 45 minutes in review of medical records and discussion with case manager; 90 minutes in scoring and report writing.

Reason for Visit

His primary care physician, S. Brooks MD, requested a competency evaluation to determine whether he is competent or has the capacity to make informed health care decisions.

History of Present Illness

On 4/7/17 he was brought to the ER and subsequently admitted to the hospital. He is unable to speak as the result of a stroke and made a 911 call because he was in medical distress. Through a miscommunication with the 911 dispatcher, in which he was pushing buttons on his phone in response to the dispatcher's prompts, it was concluded that "there was some sort of shooting versus a bomb threat resulting in police cordoning off Rhinelander downtown," according to the History and Physical written by T. Tran DO. Dr Tran further stated, "When the patient emerged from his home, police thought he was the bomber suspect, tackled him, and restrained this elderly man. He is unable to communicate verbally and was brought into the emergency room where it was discovered patient has hyperglycemia."

Since the patient's admission he has shown some confusion and it has been very difficult to determine his level of capacity due to his communication difficulties. He responds either by shaking or nodding his head or by writing a response slowly.

I explained to the patient my purpose in meeting with him and explained that the results could indicate the need for a court-appointed guardian and/or protective placement. He agreed to participate.

Medical History

PRIMARY CARE PHYSICIAN: S. Brooks MD
PAST MEDICAL HISTORY:
Recent CVA.
Parkinson's disease.
Diabetes mellitus type 2 on insulin, diagnosed 1980s.
Essential hypertension.
Bulbar weakness with severe dysarthria and upper extremity weakness, 2006.
Degenerative joint disease.
GERD.
History of asthma.
Nonverbal secondary to recent CVA with Parkinson's.

PAST SURGICAL HISTORY
Appendectomy.

*** COPY ***

Trigger finger release.
Bilateral carpal tunnel release.
Sinus surgery, 1990s.

CURRENT MEDICATIONS
VERIFIED AS ACTIVE IN MEDICATIONS MANAGER:
Acetaminophen (Tylenol®), by mouth as needed 2am 3 hs
AmLODIPine 10 mg Tablet, 1 Tablet(s) by mouth once daily
Aspirin, by mouth 81 mg 1 daily
Beclomethasone Dipropionate (Qvar®) Inhalation 80 mcg/Actuation Aerosol, 2 Puff(s) twice daily
Chlorhexidine Gluconate Mucous Membrane 0.12 % Mouthwash, 15 Milliliter(s) by mouth up to twice daily
Finasteride 5 mg Tablet, 1 Tablet(s) by mouth once daily
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100 unit/mL Insulin Pen, subcutaneously 4 units breakfast, 0-2 units lunch, 11 units dinner, +SS max daily dose = 30 units
Insulin NPH Human Recombinant (HumuLIN N KwikPen®) Subcutaneous 100 unit/mL (3 mL) Insulin Pen, subcutaneously 18 units am,18 units pm
Irbesartan 150 mg Tablet, 1 Tablet(s) by mouth once daily
Omega-3 Fatty Acids (OTC) (Natural Fish Oil®), by mouth 1000 mcg daily
Omeprazole 20 mg Capsule, Delayed Release(E.C.), 1 Capsule(s) by mouth once daily
Simvastatin 20 mg Tablet, 1/2 Tablet(s) by mouth once daily
Spironolactone 25 mg Tablet, 1 Tablet(s) by mouth once daily
Tamsulosin 0.4 mg Capsule, Sust. Release 24HR, 1 Capsule(s) by mouth once daily

Family History
FATHER: died from unknown cancer
MOTHER: deceased; had diabetes mellitus type 2, arthritis, and hypertension.

Social History
EDUCATION: patient stated 13 years of education
OCCUPATION: retired from Foster & Smith
MARRIAGE: 1; widowed
CHILDREN: 1 son and two daughters, according to the patient
No history of tobacco, alcohol, or illicit drug use
He currently lives in his own home with his son, Alan

Mental Status Examination
APPEARANCE: He was seated in a chair in his hospital room, dressed in hospital garb; hair was uncombed and he had contusions on his forehead and temple area with stitches near the temple.
AROUSAL: alert
ATTENTION/CONCENTRATION: poor
ORIENTATION: poor
MEMORY: poor
GAIT: not observed
MOTOR: psychomotor retardation

*** COPY ***

MOOD (observed): sad
AFFECT: flat
SPEECH: unable to speak
THOUGHT PROCESS: marked by confusion
THOUGHT CONTENT: erroneous and impoverished
DANGER TO SELF: none noted
DANGER TO OTHERS: absent
ESTIMATED INTELLIGENCE: could not be determined at this time
ESTIMATED FUND OF KNOWLEDGE: could not be determined at this time
INSIGHT: poor
JUDGMENT: poor

Data

Montreal Cognitive Assessment (MOCA) (portions)
Executive Functioning Assessment (portions)

EXECUTIVE FUNCTIONING
ORIENTATION: scored 5/12 (severe); gave correct age, city, and year; gave location as "Armed," gave date as March ?, '17, could not provide day of week, and misjudged time by 2 1/2 hours.
ATTENTION: scored 1/5 (severe); could repeat in writing 5 digits forward but not 3 backward; unable to perform serial 7's.
ABSTRACT REASONING: scored 0/8 (severe); unable to identify similarities between pairs of objects (e.g., apple/banana)

SHORT-TERM MEMORY
IMMEDIATE MEMORY: immediate recall of 2/5 list words with 1 intrusion on 1st trial and 3/5 list words on 2nd trial
DELAYED RECALL: free recall of 0/5 list words after 5 minutes

Assessment

The testing results and my interview with the patient lead me to conclude that he is neither competent nor capacitated to make informed health care decisions. His physician is recommending palliative care versus hospice care.

Given his confusion and disorientation and his propensity for aspiration, the patient will require 24-hour care.

Diagnoses

Major neurocognitive disorder, unspecified

Plan

Sue Kirby, palliative care social worker, will work with the family to determine the best course of action for his care.

I will complete the Examining Psychologist's Report, recommending guardianship and possible

*** COPY ***

protective placement versus 24-hour care.

I will co-sign the Declaration of Incapacity form, which Dr. Brooks has already signed.

Harriet I. Walker, PhD
Licensed Psychologist

Created: 04/11/2017

Electronically signed by Walker, Harriet I PhD on 04/11/2017 09:47.

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate: [redacted]/1952
Palliative Care Document Hosp
Service: 04/12/2017
Diane Tatrow APNP

Printed: 09/07/17
At: 08:37

*** COPY ***

REASON FOR CONSULTATION

Referring Provider/Service: Dr. Brooks, Internal Medicine

Present at Consultation: patient, NP, son Alan.

Patient seen today for advanced care planning, review treatment options/prognosis discussion, hospice evaluation and patient and family support (psychological/spiritual)

CODE STATUS:
FULL CODE

Advanced Directives: Incapacity declaration: Yes.
Date Completed: 4/10/2017
Present in Combined Medical Record: Yes

Document Dates
04/12/2017

Chief Complaint
Hyperglycemia and closed head injury.

History of Present Illness
Tom is a 65-year-old, Caucasian man with Parkinson's, bulbar weakness secondary to CVA, diabetes mellitus, who has been nonverbal for about a year-and-a-half, brought into the emergency room after sustaining a closed head injury. Tom was alone at home and recognized that he was having a hyperglycemic episode. Attempted to call 911, however, because of being nonverbal there was miscommunication with the dispatcher and thought there was an active shooter or bomb threat in his residence. The police did respond and when Tom came out of the house he was tackled to the ground, sustaining head trauma. He was brought to the ED, discovered that he had a blood sugar of 559.

Tom has been seeing speech therapy due to his dysphasia and significant weight loss. About a year-and-a-half ago he weighed as much as 280 pounds, he is now 130 pounds. This is about the time his speech became impaired. He did have a swallow study on March 3, 2017 that did show silent aspiration. He does live with his son. Tom does communicate by writing things out on a tablet. However, his son works from 1 in the morning to 12:30 in the afternoon. Tom is responsible for drawing up is own insulin and was in fact, having problems with morning hypoglycemia.

WBC 20.3, hemoglobin 17.6, hematocrit 48.4, platelet 204, MCV 92.9, RDW 12.3. INR 1.2. Troponin I less than 15. ABG 7.36/46/74/26. Sodium 135, potassium 4.1, chloride 197, bicarb 26, BUN 45,

creatinine 1.27, calcium 9.5. Blood glucose 559. Alk phos 117, ALT 55, AST 32. Magnesium 1.5. TSH is 0.98, free T4 1.5. Urine drug screening negative. Blood alcohol less than 20.

Radiology:
- Portable chest, 1 view, image reviewed by myself reveals possible right lower lobe infiltrate. Poor inspiratory effort. Loops of bowel noted in thoracic cavity, possibly due to angle.
- CT head without contrast obtained on 4/7/17: IMPRESSION: No intracranial hemorrhage or other acute abnormality by CT.
- Cervical spine with an without contrast: IMPRESSION: No acute findings on cervical spine.
- CT maxillofacial with and without contrast obtained on 4/7/17: IMPRESSION: No facial fracture identified. Superficial metallic debris along the right cheek and adjacent to the right anterior globe. Extensive periodontal disease with absent right-sided maxillary and mandibular teeth.

Tom was admitted with hyperglycemic hyperosmolic syndrome. Aspiration pneumonia suspicion of sepsis, started on IV Vancomycin and Zosyn. Closed head injury and uncontrolled hypertension.

Past Medical History

1. Recent CVA.
2. Parkinson's disease.
3. Diabetes mellitus type 2 on insulin, diagnosed 1980s.
4. Essential hypertension.
5. Bulbar weakness with severe dysarthria and upper extremity weakness, 2006.
6. Degenerative joint disease.
7. GERD.
8. History of asthma.
9. Nonverbal secondary to recent CVA with Parkinson's.

Past Surgical History

1. Appendectomy.
2. Trigger finger release.
3. Bilateral carpal tunnel release.
4. Sinus surgery, 1990s.

Medications

1. Zosyn 3.375 grams IV every 8 hours.
2. Novolog subcu per sliding scale 4 times daily.
3. DuoNeb nebulizer every 8 hours.
4. Sinemet 25/100, 3 times daily.
5. Chlorhexidine gluconate 15 mL twice daily swish and spit.
6. Novolog N insulin 8 units subcu twice daily.
7. Spironolactone 25 mg daily.
8. Aspirin 81 mg daily.
9. Losartan 50 mg daily.
10. Tamsulosin 0.4 mg daily.
11. Amlodipine 10 mg daily.

12. Finasteride 5 mg daily.
13. Pantoprazole 20 mg daily.
14. Simvastatin 10 mg daily.
15. Acetaminophen 500 mg every 6 hours as needed for pain or fever.
16. Hydrocodone/Acetaminophen 5/325 every 4 hours as needed for pain, one dose in the last 24 hours.
17. Ondansetron ODT 8 mg every 8 hours as needed for nausea and vomiting.

Allergies
Hydrochlorothiazide: possible pancreatitis
Liraglutide Subcutaneous (Victoza 2-Pak®): Nausea

Family History
Mother: deceased, history of DM
Father: deceased, some type of cancer.
Siblings: 2, 1 sister deceased.
Children: 2 sons, 1 daughter.

Social History
Marital status: Widowed
Work details: Retired
Occupational history: Worked at Twist Drill until it closed, then Foster and Smith up to 3 years ago.
Military history (if applicable): none
Toxic habits: none
Resides at: Home. Home Care Services: No.
Primary caregiver: Son Alan.
Hobbies/Interests: loved to fish. Was a bowler with many trophies.

Psychosocial/Cultural/Spiritual History:
Tell me about yourself: Information obtained from Tom's son, Alan. Tom grew up in Rhinelander, graduated from high school here. He had a brother as well as a sister and his sister died very young, may have even been in infancy. He did go to Nicolet College and earned a small engine degree, worked at Twist Drill until it closed. Loved to fish, loved to bowl, had trophies for 300 games. He has 2 cats which walk outside with him. Alan describes his dad as very stoic, has never liked to talk about feelings. Tom became a widower about 2 years ago and has never really talked about that loss. Alan then moved in with his dad around that same time as he could see his dad was beginning to fail.
Cultural/Language preference: English
Family support: Son, Alan, lives with him and provides as much support as he can.
Patient/family coping: Tom has had significant weight loss, difficulty eating and swallowing. Has been nonverbal for about a year-and-a-half, although only recently diagnosed with Parkinson's. Along with losing his wife just 2 years ago, has had a lot of losses that he is trying to deal with.
Financial Concerns/Insurance coverage: Self pay. Medicaid papers in the works.

Role of faith/spirituality: unknown
Spiritual concerns: none voiced.

*** COPY ***

Review of Systems
Tom is able to indicate to me that he has pain in the right cheek and right temple. His appetite is fair. He would like to shave. He had urinary retention, now has a Foley. He would like to get up and walk but writes that he does not need a walker. Ten point ROS otherwise unable to obtain due to the communication difficulties.

Examination
GENERAL: Pale, elderly, appearing much older than 65 years. No acute distress.
VITALS: Temperature 97.7, pulse 68, respirations 20, BP 125/71, O2 95% on room air. Weight is 60.8 kilograms, that is down 12 kilograms in about 2 months but son reports about 130 pound weight loss over the last year.

FUNCTIONAL STATUS:
PALLIATIVE PERFORMANCE SCORE (PPS): 40%

HEENT: He does have excoriation as scabbing areas on the right cheek and the right forehead. No scleral icterus. Oral mucosa is pink and dry. He does have bits of food in his mouth.
RESPIRATORY: Clear to auscultation, unlabored.
CARDIOVASCULAR: Irregular rate and rhythm, S1, S1.
ABDOMEN: Abdomen is soft, nontender, bowel sounds normoactive.
GU: He has a Foley with pale yellow urine.
INTEGUMENT: Age-appropriate. No rashes or petechia. Skin is warm and dry.
NEUROLOGIC: He is alert, is able to make his needs known by writing down. Does recognize his family members and is able to write the names of his grandchildren.
PSYCHIATRIC: Normal affect.

Laboratory/X-Ray
Glucose now controlled, latest measurement of 155. White count 5.4, hemoglobin 14.3, platelet count 156.

Impression
A 65-year-old man with Parkinson's, significant weight loss, nonverbal status, history of aspiration admitted with closed head injury following trauma, found to be hyperglycemic with diabetes, that is now controlled. Likely aspiration pneumonia without sepsis. Palliative care was consulted for hospice evaluation, patient and family support as well as advanced care planning.

He has no POA for healthcare. Patient was deemed to be incapacitated on 04/10/2017, son wishes to pursue guardianship.

I met with Tom and his son, Alan. Although Alan would love to take him home he realizes that he cannot provide the 24/7 care that Tom now needs. He is pursuing placement for his dad's safety and care. We discussed hospice as an added level of support. He certainly would be eligible due to his significant weight loss, being nonverbal, dramatic decline in functional capacity.

With Alan's okay, I did share all of the above plans with Tom including the nursing home placement. Tom's concern was being able to attend a birthday party this coming Sunday for one of the grandchildren.

Plan

Based on conversation with patient (and family):

1. GOALS OF CARE: Safety and comfort are primary concerns of his son. He has been accepted at Friendly Village Nursing Home pending the guardianship filing and Medicaid paperwork. We will also make a referral to hospice.
2. CODE STATUS: On the admission papers it said DNR, however, he is still listed as a FULL CODE. I did discuss a community DNR bracelet and both Alan and Tom would like that.
3. ADVANCE DIRECTIVES: He does not have any and so guardianship is being pursued.
4. SYMPTOMS: Symptoms of hyperglycemia now under control.
5. DISPOSITION: Transition to Friendly Village Nursing Home with hospice support once the guardianship has been filed.

The above plan of care/recommendations have been discussed/shared with Dr. Brooks and nursing staff, as well as case management.

Total time spent 60 minutes, from 940 to 1040 greater than 50% was spent in counseling and coordination of care, discussing the patient's condition, prognosis and options for care including hospice.

Thank you for the opportunity to participate in the care of this patient. We will continue to follow with you.

Diane Tatrow, NP, ACHPN/dj
Palliative Care

Dictated: 04/12/2017 at 11:13
Transcribed: 04/12/2017 at 12:03

EC:
Olumuyiwa Adeboye MD
Steven R Brooks MD

Electronically signed by Tatrow, Diane APNP on 04/12/2017 12:52.

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate: [redacted]1/1952
Discharge Medication List
Service: 04/14/2017
Steven R Brooks MD

Printed: 09/07/17
At: 08:37

*** COPY ***

DISCHARGE MEDICATION LIST
MHC-ST MARY'S-RHINELANDER

Discharge Medications

NEW/REPRESCRIBED:
Amoxicillin-Pot Clavulanate 875-125 mg Tablet Disp: 10 Tablet(s) Refills: 0
Sig: 1 Tablet(s) by mouth every twelve hours for 5 day course
04/14/2017 @ 07:17 By Brooks, Steven R MD
LORazepam 0.5 mg Tablet Disp: 56 Tablet(s) Refills: 1
Sig: 1 Tablet(s) (0.5 mg) by mouth four times daily as needed
04/14/2017 @ 07:17 By Brooks, Steven R MD
Morphine Concentrate 100 mg/5 mL (20 mg/mL) Solution Disp: 30 Milliliter(s) Refills: 0
Sig: by mouth 0.25ml -1ml every hour as needed
04/14/2017 @ 07:17 By Brooks, Steven R MD

TAKE:
Acetaminophen (Tylenol®)
Sig: by mouth as needed 2am 3 hs
AmLODIPine 10 mg Tablet
Sig: 1 Tablet(s) (10 mg) by mouth once daily
07/20/2016 @ 08:01 By Brooks, Steven R MD
Aspirin
Sig: by mouth 81 mg 1 daily
Blood Sugar Diagnostic (Accu-Chek Aviva Plus Test Strip®) Miscell. (Med.Supl.;Non-Drugs) Strip
Sig: 1 Strip(s) six times daily
02/10/2016 @ 09:51 By Brooks, Steven R MD
Blood Sugar Diagnostic, Drum (Accu-Chek Compact Plus Test®) Miscell. (Med.Supl.;Non-Drugs) Strip
Sig: 1 Strip(s) four to six times daily
08/17/2015 @ 12:38 By Brooks, Steven R MD
Blood-Glucose Meter (Accu-Chek Aviva Plus Meter®) Miscell. (Med.Supl.;Non-Drugs) Misc
Sig: As directed SIX TIMES DAILY
02/10/2016 @ 09:51 By Brooks, Steven R MD
Chlorhexidine Gluconate Mucous Membrane 0.12 % Mouthwash
Sig: 15 Milliliter(s) by mouth up to twice daily Swish in mouth for 30 seconds and spit out
08/24/2016 @ 13:38 By Kaur, Kirandeep DDS
Finasteride 5 mg Tablet
Sig: 1 Tablet(s) (5 mg) by mouth once daily
10/18/2016 @ 09:21 By Brooks, Steven R MD
Insulin Needles (BD Insulin Pen Needle UF Mini®) Miscell. (Med.Supl.;Non-Drugs) 31 gauge x 3/16" Needle
Sig: 1 Needle(s) five times daily

01/03/2017 @ 13:20 By Brooks, Steven R MD
Insulin Syringe-Needle U-100 Miscell. (Med.Supl.;Non-Drugs) Syringe
Sig: 1 Syringe(s) subcutaneously four to six times daily
07/20/2016 @ 08:01 By Brooks, Steven R MD
Irbesartan 150 mg Tablet
Sig: 1 Tablet(s) (150 mg) by mouth once daily
05/23/2016 @ 08:40 By Brooks, Steven R MD
Lancets (Soft Touch Lancets®) Miscell. (Med.Supl.;Non-Drugs) Misc
Sig: 1 Lancet(s) six times daily
02/10/2016 @ 09:51 By Brooks, Steven R MD
Omega-3 Fatty Acids (OTC) (Natural Fish Oil®)
Sig: by mouth 1000 mcg daily
Omeprazole 20 mg Capsule, Delayed Release(E.C.)
Sig: 1 Capsule(s) (20 mg) by mouth once daily
01/19/2017 @ 11:34 By Brooks, Steven R MD
Spironolactone 25 mg Tablet
Sig: 1 Tablet(s) (25 mg) by mouth once daily
10/18/2016 @ 09:21 By Brooks, Steven R MD
Tamsulosin 0.4 mg Capsule, Sust. Release 24HR
Sig: 1 Capsule(s) (0.4 mg) by mouth once daily
02/08/2017 @ 15:15 By Brooks, Steven R MD

TAKE (Modified):
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100 unit/mL Insulin Pen
Sig: subcutaneously SS 1 unit for 50>150 max daily dose = 30units
01/03/2017 @ 13:20 By Brooks, Steven R MD
Insulin NPH Human Recombinant (Humulin N KwikPen®) Subcutaneous 100 unit/mL (3 mL) Insulin Pen
Sig: subcutaneously 8 units am,8 units pm
01/03/2017 @ 13:20 By Brooks, Steven R MD

SUSPEND:
Beclomethasone Dipropionate (Qvar®) Inhalation 80 mcg/Actuation Aerosol
Sig: 2 Puff(s) twice daily
01/19/2017 @ 11:34 By Brooks, Steven R MD

DISCONTINUE:
Simvastatin 20 mg Tablet
Sig: 1/2 Tablet(s) (10 mg) by mouth once daily
11/30/2016 @ 11:02 By Brooks, Steven R MD

Plan

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Discharge Medication List, Page 3 *** COPY ***

Delivery: Given to/picked up by patient on 04/14/17

Note: Additional medications started during hospitalization and active on the day of discharge were also reconciled with the Discharge Medication List.
This list may have been developed by entries from more than one provider or provider service. See Clinical Medications Manager for the specific entry detail for each medication.

Steven R. Brooks, MD
Internal Medicine

Created: 04/14/2017

Electronically signed by Brooks, Steven R MD on 04/14/2017 07:20.

PLA 077

Ministry Saint Mary's Hospital
Rhinelander, WI

MHN: 956883
Patient: Thomas A Smith
Gender: Male Birthdate [redacted]/1952
Hosp Discharge Summary
Service: 04/14/2017
Steven R Brooks MD

Printed: 09/07/17
At: 08:37

*** COPY ***

Document Dates
AMENDED REPORT

Admission Date: 04/07/2017
Discharge Date: 04/15/2017

History
This 65-year-old, nonverbal, Caucasian male with a history of diabetes mellitus type 2, CKD stage 3, bulbar weakness secondary to CVA, Parkinson's, and diabetes mellitus type 2 is brought in to the emergency room after sustaining a closed-head injury. Apparently this patient is unable to speak and had some issues where he believed he was in distress. He does not have a TTY machine at home, attempted to call 9-1-1 and through a lot of miscommunication 9-1-1 dispatcher concluded there was some sort of shooting versus a bomb threat resulting in police cordoning off downtown Rhinelander.

According to patient's son, when patient emerged from his home, police thought he was the bomber/shooter suspect and proceeded to tackle and restrain this elderly man. He is unable to communicate verbally and was brought into the emergency room where it was discovered patient has hyperglycemia. Most of the history is obtained from his son since the patient is nonverbal and only able to communicate via written form. History is limited because of communication difficulties.

According to the son, primary care provider lowered the evening NPH to 18 units because of morning hypoglycemia. The patient has difficulty drawing up his own insulin and son questions if patient is able to administering insulin correctly. Patient's son says they are working to get Medicaid/Medicare coverage and additional assistance.

Patient has been seeing a speech therapist due to dysphagia issues. There is suspicion patient is silently aspirating per speech therapist's note. The patient has been losing approximately 7-8 pounds per week due to poor appetite. Patient denies any fevers, chills or body aches by shaking his head. No other active issues are obtainable at this time.

The above history section was copied by Transcription from the Hospital History and Physical dated 04/07/2017 authored by Dr. Tran at the direction of the clinician author.

Examination
VITAL SIGNS: Temperature 97.6, blood pressure 159/105, pulse 118, respirations 22, O2 saturation 93% on 2 liters.
GENERAL: Cachectic Caucasian male, nonverbal, disheveled appearance.
SKIN: The patient has abrasions on the right periorbital temporal region. Discoloration around the perioral region as well from emesis in the past. Multiple nevi in posterior back.
HEENT: Head: The patient appears to have a suffered a closed-head injury with bleeding on the right temporal region. Normocephalic. Ears: No tenderness or discharge. Auditory acuity cannot be assessed

due to patient condition. Nose/sinuses: No inflammation of the nasal mucosa/septum/turbinates. Maxillary and frontal sinuses are mildly tender. Posterior pharynx and oral mucosa are dry.
BACK: Limited examination due to decreased range of motion.
HEART: Barely audible S1, S2. Mild systolic murmur appreciated left sternal border.
LUNGS: Diminished lung sounds diffusely. Mild expiratory wheezes on the right base.
ABDOMEN: Bowel sounds in all 4 quadrants. No rebound, guarding or hepatosplenomegaly appreciated.
MUSCULOSKELETAL: Decreased range of motion and physical deconditioning. Atrophy in muscles diffusely.
NEUROLOGICAL: Limited examination due to patient condition. The patient is nonverbal. Reflexes in the triceps, biceps, brachial radialis are 2/4 bilaterally. Negative Babinski. Cerebellar and finger-to-nose test grossly intact.
PSYCHOLOGICAL: Limited examination due to patient condition. The patient appears to have mild dementia.

The above examination was copied by Transcription from the Hospital History and Physical dated 04/07/2017 authored by Dr. Tran at the direction of the clinician author.

Hospital Course

1. Patient with pneumonia, right lower lobe, thought to be consistent with aspiration with his multiple system atrophy. He was placed on IV Zosyn and responded to this and patient improved. It was not felt the patient was septic. Blood sugars were quite high on admission and he was started back on some NPH insulin and NovoLog sliding scale and blood sugars improved substantially during this hospitalization.
2. Patient developed some urinary retention several days into the hospitalization and Foley catheter had to be placed and the patient was tolerating that well. It was felt we should keep the Foley catheter in for a week and then re-assess and try to remove.
3. Multiple system atrophy, parkinsonian type, severe and progressive. Palliative Care consult was obtained and felt he was hospice candidate. Also guardianship process was begun while here as it was felt patient was not capable of complex decision making and there was no healthcare power of attorney that had been done prior to this hospitalization. It was felt the patient could go home with caregivers with 24/7 monitoring and this is being arranged by his son, Allen.

Discharge Instructions

1. Follow up with myself as needed.
2. Activity: Walk with walker and patient to have standby assist.
3. Foley to gravity.
4. Chemsticks t.i.d.

Discharge Medications

Active Medications List for Smith, Thomas A (956883)
As of: 04/16/2017 @ 07:59am

Active:
Acetaminophen (Tylenol®)

Sig: by mouth as needed 2am 3 hs
AmLODIPine 10mg Tablet
Sig: 1 Tablet(s) (10 mg) by mouth once daily
Amoxicillin-Pot Clavulanate 875-125mg Tablet
Sig: 1 Tablet(s) by mouth every twelve hours
Aspirin
Sig: by mouth 81 mg 1 daily
<Suspended> Beclomethasone Dipropionate (Qvar®) Inhalation 80mcg/Actuation Aerosol
Sig: 2 Puff(s) twice daily
Blood Sugar Diagnostic (Accu-Chek Aviva Plus Test Strip®) Miscell. (Med.Supl.;Non-Drugs) Strip
Sig: 1 Strip(s) six times daily
Blood Sugar Diagnostic, Drum (Accu-Chek Compact Plus Test®) Miscell. (Med.Supl.;Non-Drugs) Strip
Sig: 1 Strip(s) four to six times daily
Blood-Glucose Meter (Accu-Chek Aviva Plus Meter®) Miscell. (Med.Supl.;Non-Drugs) Misc
Sig: As directed SIX TIMES DAILY
Chlorhexidine Gluconate Mucous Membrane 0.12% Mouthwash
Sig: 15 Milliliter(s) by mouth up to twice daily Swish in mouth for 30 seconds and spit out
Finasteride 5mg Tablet
Sig: 1 Tablet(s) (5 mg) by mouth once daily
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100unit/mL Insulin Pen
Sig: subcutaneously SS 1 unit for 50>150 max daily dose = 30units
Insulin Needles (BD Insulin Pen Needle UF Mini®) Miscell. (Med.Supl.;Non-Drugs) 31 gaugex 3/16" Needle
Sig: 1 Needle(s) five times daily
Insulin NPH Human Recombinant (Humulin N KwikPen®) Subcutaneous 100 unit/mL(3 mL) Insulin Pen
Sig: subcutaneously 8 units am,8 units pm
Insulin Syringe-Needle U-100 Miscell. (Med.Supl.;Non-Drugs) Syringe
Sig: 1 Syringe(s) subcutaneously four to six times daily
Irbesartan 150mg Tablet
Sig: 1 Tablet(s) (150 mg) by mouth once daily
Lancets (Soft Touch Lancets®) Miscell. (Med.Supl.;Non-Drugs) Misc
Sig: 1 Lancet(s) six times daily
LORazepam 0.5mg Tablet
Sig: 1 Tablet(s) (0.5 mg) by mouth four times daily as needed
Morphine Concentrate 100 mg/5 mL(20 mg/mL) Solution
Sig: by mouth 0.25ml -1ml every hour as needed
Omega-3 Fatty Acids (OTC) (Natural Fish Oil®)
Sig: by mouth 1000 mcg daily
Omeprazole 20mg Capsule, Delayed Release(E.C.)
Sig: 1 Capsule(s) (20 mg) by mouth once daily
Spironolactone 25mg Tablet
Sig: 1 Tablet(s) (25 mg) by mouth once daily
Tamsulosin 0.4mg Capsule, Sust. Release 24HR

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Sig: 1 Capsule(s) (0.4 mg) by mouth once daily

CONDITION AT DISCHARGE
Needing help with ADLs.

Disposition

Patient to be discharged to home with hospice and in-home caregivers.

Final Diagnosis

1. Pneumonia, right lower lobe, consistent with aspiration without sepsis.
2. Closed-head injury with abrasion/laceration of the right periorbital region.
3. Type 2 diabetes with hyperglycemia, chronic.
4. Urinary retention, acute.
5. Multiple system atrophy, parkinsonian type, chronic, severe and progressive.
6. Chronic kidney disease, stage 3.
7. Cachectic with weight loss secondary to the multiple system atrophy.

Steven R. Brooks, MD/sp
Internal Medicine

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Amended Text: 04/20/2017 at 12:43

Electronically signed by Brooks, Steven R MD on 04/20/2017 13:42.